Section III

Federal Award Findings and Questioned Costs

Department of Health Care Policy and Financing

Introduction

The Department of Health Care Policy and Financing (HCPF) was created as part of the restructuring of State departments under House Bill 93-1317 effective on July 1, 1994, or the beginning of Fiscal Year 1995. The Department is the State agency responsible for administering the Medicaid program, the federal program designed to provide health services to eligible needy persons. HCPF contracts with the Department of Human Services for some services, such as determining individuals' eligibility for Medicaid benefits. The Medicaid grant is the largest federal program administered by the State and is funded approximately equally by federal funds and state general funds. During Fiscal Year 1999 the Department expended almost $1.91 billion and had 159 full-time-equivalent staff (FTE), compared with $1.67 billion in expenditures and 146 FTE in Fiscal Year 1998.

During Fiscal Year 1999 the Department continued to work on developing an expanded children's health insurance program for children 18 years of age and under as authorized by House Bill 97-1304, referred to as the Children's Basic Health Plan or Children's Health Plan Plus. In October of 1997 the Department submitted the State's plan for children's health insurance to the federal government in order to obtain federal funds for these types of programs under the federal Title XXI, the Children's Health Insurance Program.

The public accounting firm of Baird, Kurtz & Dobson (BKD) performed the audit work at HCPF as of and for the fiscal year ended June 30, 1999. During its audit BKD reviewed and tested HCPF's internal controls over financial reporting and federal programs, including compliance with certain state and federal laws and regulations, as required by generally accepted auditing standards, *Government Auditing Standards* and U.S. Office of Management and Budget (OMB) Circular A-133.

Obtain Approval for Cost Allocation Plans

See Recommendation No. 2 in Section II of the Schedule of Findings and Questioned Costs.

Improve Oversight of the Medicaid Program

The audit reviewed the Department of Health Care Policy and Financing's procedures for complying with other federal requirements for the Medicaid program such as determining the eligibility of individuals and providers under the program, making payments only for allowable costs, and monitoring controls over automated systems essential to the program. To assist it in carrying out the Medicaid program, the Department relies on the Department of Human Services and a nongovernmental contractor to perform specific functions. However, under federal regulations the Department of Health Care Policy and Financing remains ultimately responsible for the Medicaid program. Therefore, HCPF must have control procedures in place to ensure compliance with state and federal regulations for all aspects of the Medicaid program, whether performed directly by the Department or by another entity through contractual or other formal agreements.

Determination of Individuals' Eligibility

Under the Medicaid program, the Department is responsible for determining the eligibility of individuals to receive Medicaid benefits. In addition, the Department must determine the eligibility of medical providers to be reimbursed for services performed under the Medicaid program for those eligible individuals. For Fiscal Year 1999, HCPF paid Medicaid benefits to various providers in excess of $1.76 billion on behalf of individual beneficiaries.

Timely Review of Single Entry Point Entities

The Department of Health Care Policy and Financing has established an agreement with the Department of Human Services (DHS) to oversee the determination of individuals' eligibility for Medicaid benefits in accordance with federal regulations. DHS accomplishes the eligibility determination process through various entities that

serve as the Single Entry Points (SEPs) for the Medicaid program. Often the SEP is a local county department of social services. In order to ensure that benefits are paid only to eligible recipients, HCPF must monitor the Department of Human Services' oversight of the SEPs.

Under the agreement between HCPF and DHS, the Department of Human Services is responsible for performing the following three procedures to monitor the SEPs and their role in the Medicaid program:

- Obtaining and reviewing the SEPs' Single Audit reports, which are performed by independent public accounting firms annually and must report any identified problems with compliance related to federal programs.

- Conducting detailed compliance audits of the SEPs.

- Conducting performance audits of the SEPs.

The audit found that of the three areas, HCPF only reviews or monitors the Department of Human Services' activities related to the performance audits of the SEPs. Performance audits were performed and monitored by HCPF for all SEPs tested.

For the compliance audits, we selected five SEPs for testing out of a total of 25 entities. We found that in four of the five cases, the SEPs' compliance audits were not performed timely. For these four SEPs, in two instances the most recent compliance audits available were for the Fiscal Year 1995, and for the other two instances, the most recent were for the Fiscal Year 1996.

In terms of the review of Single Audit reports, DHS had received the Single Audit reports timely for all SEPs but one. However, HCPF did not monitor or know the results of DHS's review of these audits. Therefore, HCPF did not have information about compliance problems that may have been identified or what action DHS had taken to resolve the problems. (CFDA Nos. 93.775, 93.777 and 93.778—Medicaid Cluster—Subrecipient Monitoring.)

Testing of Files for Individuals' Eligibility

The audit also included testing of a sample of Medicaid expenditures to determine whether or not the payments made were for individuals that were eligible for Medicaid benefits. As discussed above, client eligibility is determined by the SEPs. The audit tested 217 expenditures, and we identified 10 instances of client eligibility errors with a value of $5,256 (federal share $2,659) described as follows:

- In two instances, a beneficiary's file did not contain information sufficient to determine whether the beneficiary was eligible to receive services under the Medicaid program.

- In one instance, a client's case file indicated they were not eligible for federal Supplemental Security Income (SSI). According to the client's eligibility type, they needed to qualify for SSI in order to receive Medicaid benefits. There was no indication the individual qualified under other criteria.

- In seven instances related to one Primary Care Physician (PCP) program incentive payment covering a six-month period of time prior to January 1, 1999, the Department of Health Care Policy and Finance was unable to provide information about the specific Medicaid recipients on behalf of whom the payments were made. Without this supporting documentation, we could not determine whether or not these recipients were eligible for benefits under the Medicaid program.

According to federal regulations, clients must be eligible for the Medicaid program in order to receive benefits (42 CFR Part 435, Subparts G and H). By not ensuring that SEPs are adequately and appropriately determining client eligibility, HCPF risks that benefits may be paid on behalf of ineligible individuals. If incorrect payments are made on behalf of individuals as a result of errors in the eligibility determination process, the Department would have to repay to the federal government any Medicaid monies previously reimbursed to the State for these individuals.

Beginning January 1, 1999, HCPF is utilizing its automated Medicaid Management Information System for the PCP incentive payments, which makes these payments on a monthly basis. The remittance generated includes the necessary client detail, and this should address the problem identified in this area. However, the Department needs to improve controls to ensure that benefits are paid only for eligible individuals and that information maintained in client files adequately documents individuals' eligibility. (CFDA Nos. 93.775, 93.777 and 93.778—Medicaid Cluster—Eligibility (Client Eligibility).)

Recommendation No. 23:

The Department of Health Care Policy and Financing (HCPF) should strengthen controls over Medicaid client eligibility processes by:

a. Reviewing on a regular basis the Department of Human Services' performance of the Single Entry Point monitoring responsibilities and following up on all

errors and inconsistencies. HCPF should document the process it performs and the results of its reviews.

b. Working with the Department of Human Services to implement control policies and testing procedures to ensure all county departments of social services are maintaining current and complete files for Medicaid-eligible beneficiaries.

c. Establishing control procedures to ensure claims are not being paid for an individual that is ineligible for benefits and to ensure individuals that no longer meet eligibility requirements are disenrolled from the Medicaid program.

Department of Health Care Policy and Financing Response:

a. Agree. The existing process will be improved by adding responsibilities for timely notification of audit report receipt by DHS; identification of necessary follow-up activities by HCPF and/or DHS; and the implementation of an automated tracking procedure at HCPF for the status of Single Audit Act reports and the compliance and performance audits performed by DHS. This requirement will be effective December 1, 1999.

b. Agree. The Department of Health Care Policy and Financing in cooperation with the Department of Human Services will utilize Medicaid Eligibility Quality Control projects to test and review eligibility and case documentation in error-prone program areas. In addition, the Eligibility and Enrollment Section has developed a best practices manual to be used by counties as an aid to client file organization and documentation. This will be distributed to the counties in December 1999.

c. Agree. The MMIS does have in place internal systems edits that prevent the system from paying for an individual that is ineligible for benefits according to the COIN (Client Oriented Information Network) eligibility information we receive from the DHS. The client information is input daily at the county level. The Department will work with DHS to improve the timeliness of data entered into the COIN system. This process will begin immediately and a statement regarding this will be included in the Memorandum of Understanding between HCPF and DHS when it is renewed on July 1, 2000.

Payments to Eligible Providers Under Medicaid

The Department of Health Care Policy and Financing contracts with a private service organization to function as a fiscal agent for the Medicaid program. Among other things, this organization is responsible for ensuring that payments are made only to those medical providers that are eligible to provide services and receive reimbursements under Medicaid.

Adequate Documentation of Provider Eligibility

As part of the fiscal agent's responsibility, it must maintain documentation to support that the medical provider receiving payments is an eligible Medicaid provider.

Out of the sample of 217 Medicaid expenditures tested, the audit found 131 instances of provider eligibility errors. In some cases, more than one type of error was identified with a particular provider. The total value of payments made to providers for which one or more errors were identified was $499,359 (federal share $252,626). Payments to ineligible providers subject the State to the risk that the Department will have to refund monies previously reimbursed by the federal government. As mentioned earlier, the total claims paid under the Medicaid program were in excess of $1.76 billion for Fiscal Year 1999.

The audit identified errors described as follows:

- There were 64 instances where the provider files did not contain a signed copy of the provider agreement. According to federal regulations (42 CFR §431.107), there must be an agreement between the Medicaid agency and each provider furnishing services for which reimbursement is claimed.

- Provider files lacked documentation of required licenses as follows:

  √ Fifty-three providers lacked the required license from the Department of Public Health.

  √ Sixteen Durable Medical Equipment (DME) providers lacked the required business or sales and excise tax license.

- √ One DME provider had a license that was expired.
- √ Two physician services providers lacked the required state license.
- √ Thirty-three pharmacy providers lacked the required pharmacy license.

In order to receive Medicaid payments, providers of medical services must be licensed in accordance with federal, state, and local laws and regulations to participate in the Medicaid program (42 CFR §431.107 and 447.10; and §1902(a)(9) of the Social Security Act). (CFDA Nos. 93.775, 93.777 and 93.778—Medicaid Cluster—Eligibility (Provider Eligibility).)

Mental Health Service Providers

The Department of Health Care Policy and Financing has an interagency agreement with the Department of Human Services, Office of Health & Rehabilitation Services, Division of Mental Health Services (DHS Mental Health Services) which states that the DHS Mental Health Services is responsible for monitoring licensing and certification of mental health centers and Mental Health Assessment and Services Agencies under the Medicaid program. While our audit did not identify any instances in which these entities had their licenses discontinued or revoked, we did note that there is no provision in the interagency agreement for notification of HCPF should such an event occur. If HCPF is not notified when a license is discontinued or revoked, the Department risks paying claims to an ineligible provider. This is another type of situation in which the Department could be required to reimburse the federal government for payments made to ineligible providers under the Medicaid program.

Recommendation No. 24:

The Department of Health Care Policy and Financing should improve controls over the provider eligibility by:

a. Requiring the fiscal agent to review all provider files to ensure each file includes a current provider agreement and documentation of applicable provider licenses.

b. Revising control procedures to ensure expenditures are made only to eligible providers.

c. Including provisions in the interagency agreement with the Department of Human Services, Division of Mental Health Services, that require notification of HCPF in the event a mental health provider loses its license or certification under the Medicaid program.

Department of Health Care Policy and Financing Response:

a. Agree. Meetings with the fiscal agent and the Department have already occurred and continue towards implementing the review of all provider enrollments, which would start with the oldest to the newest. The Department had agreed in the former audit in July to complete the re-enrollment by July 1, 2005.

b. Agree. The current provider files contain all required documents, which are based on current control procedures. The audit consisted of those files that were transferred from Blue Cross/Blue Shield of Colorado and due to many possible reasons the required information was missing. Once these files are reviewed based on Recommendation No. 25a, all files will be in compliance.

c. Agree. These provisions will be included in our discussions with DHS on the next interagency agreement which will be renewed on July 1, 2000. However, due to the limited number of community mental health centers and our frequent contact with Human Services on mental health issues, this would make no change in HCPF's role as the single state agency for Medicaid.

Allowable Costs Under Medicaid

See Recommendation No.3 in Section II of the Schedule of Findings and Questioned Costs.

Controls Over Automated Systems for Medicaid

See Recommendation No. 4 in Section II of the Schedule of Findings and Questioned Costs.

Medicaid Managed Care Programs and Complaint Systems

HCPF has a waiver from the federal government allowing the Department to operate a Managed Care Program (MCP). Under the Managed Care Program, the Department is required to ensure that beneficiaries have adequate access to health care through the MCP. The managed care organizations are paid premiums by Medicaid on behalf of the beneficiaries served. As part of the audit, a sample of 30 managed care organization billing submissions and related agreements and other documentation was selected for testing out of a population of 591 such organizations providing services under the Department's MCP.

This testing disclosed one organization that was not providing an adequate complaint system. The Department had also performed an audit of this provider and determined the complaint system was inadequate. The Department is working on the corrective action plan with the provider.

In addition, two submissions tested under Programs for All Inclusive Care for the Elderly (PACE) lacked the participant identification numbers and categorical descriptions of the nature of particular complaints. This information is required according to the 1999 PACE Managed Care contract. However, more importantly this information helps to record, track, and resolve the participant's complaint and is required under federal regulations. (CFDA Nos. 93.775, 93.777 and 93.778—Medicaid Cluster—Special Tests and Provisions (Managed Care Program).)

Recommendation No. 25:

The Department of Health Care Policy and Financing should ensure all necessary information is maintained regarding complaints under the Medicaid Managed Care Program by requiring all complaints under the Programs for All Inclusive Care for the

Elderly (PACE) be reviewed for completeness of information. In addition, the Department should continue to monitor providers participating in the managed care program and follow up on those not meeting program requirements.

Department of Health Care Policy and Financing Response:

Agree. The Department is currently monitoring the complaint processes of all Medicaid-contracted HMOs and following up to ensure complete compliance. Corrective Action Plans have been required from the HMOs on all areas requiring improvement. The Department is planning another extensive audit of the HMOs' complaint processes in year 2000.

The PACE contractor collects and maintains complaints by utilizing a prescribed form for recording the complaint, and by listing all such complaints on an internal log. The Department requires the contractor to submit copies of the complaints on a quarterly basis. This is a small population of Medicaid clients, currently less than 300. Because of the vulnerability of the population, it is the Department's practice to review each complaint. The participant's name is included on the form, and the Health Plan Manager maintains a list of all participants. The Department will review and follow the policies regarding recording, tracking and resolving participant complaints. This will begin January 1, 2000.

Adequacy of Documentation in Medicaid Fraud Case Files

While testing selected cases from the Colorado Medicaid Fraud Unit (MFCU), we noted the case files were disorganized and chronological logs used to document the progress of the case were incomplete. In order to learn the disposition of the cases tested, the auditors were required to interview the respective investigator for the case. This lack of documentation results in dependence on Department personnel, which could become a problem if staff turnover occurs or if personnel must be absent for other reasons. HCPF should ensure that adequate documentation exists in the files to enable personnel other than the investigator to reasonably determine the progress and disposition of fraud cases under investigation. The Department indicates that, subsequent to our testing, a new policy on file organization was implemented in the Medicaid Fraud Unit.

Recommendation No. 26:

The Department of Health Care Policy and Financing should improve documentation of fraud cases by requiring that case files contain supporting documentation in chronological order from case opening to disposition with a corresponding log of the case history.

Department of Health Care Policy and Financing Response:

Agree. The MFCU has implemented a new policy on file organization, which should improve documentation of fraud cases. It requires case files contain supporting documentation in chronological order from case opening to disposition with a corresponding log of the case history. In addition the Program Integrity Unit within the Department now receives a case status report monthly on all cases referred to the MFCU. This report includes detailed information on the case including case name, investigator as well prosecutor, case description, current status, and other identifying information.

Drawdowns of Federal Funds for the Medicaid Program

See Recommendation No. 5 in Section II of the Schedule of Findings and Questioned Costs.

Strengthen Monitoring and Reporting for the Children's Health Insurance Program

See Recommendation No. 6 in Section II of the Schedule of Findings and Questioned Costs.

Medicaid Fraud and Abuse

The Department of Health Care Policy and Financing is the single state agency responsible for managing the Medicaid program. Medicaid is a federal- and state-funded program that provides health care for children, adults, and families based on income level and medical or physical conditions. During Fiscal Year 1998, the Medicaid program served more than 258,000 Colorado residents. Medicaid expenditures, excluding mental health and developmental disabilities services overseen by the Department of Human Services, were about $1.1 billion.

Over the past five years, Medicaid expenditures at the Department of Health Care Policy and Financing have increased by $280 million, or 35 percent, while the number of Medicaid recipients has declined by over 8 percent. The magnitude of expenditures and volume of services increase the risk of Medicaid fraud and abuse.
The public accounting firm of Clifton Gunderson L.L.C., performed the audit work of the Medicaid fraud and abuse programs during Fiscal Year 1999. The following comments were addressed in the *July 1999 Medicaid Fraud and Abuse Programs Performance Audit* report prepared by Clifton Gunderson L.L.C.

Detecting Fraud and Abuse

The General Assembly and the Medicaid program want to be sure that, as health care costs continue to increase, all Medicaid services and payments are appropriate and misuses and inefficiencies are identified promptly. Effective, comprehensive strategies to identify, recover, and deter inappropriate services and payments are the key to providing this assurance to taxpayers.

This section reviews the Medicaid program's efforts to detect and recover inappropriate payments and compares Colorado's efforts with best practices in other states. Overall, we found that the Medicaid program should improve its oversight of fraud and abuse and strengthen practices for identifying and pursuing recoveries. Over a three-month period, our audit identified over $3.3 million in potential recoveries resulting from gaps in fraud and abuse detection activities and weaknesses in program practices. On the basis of estimates prepared by the federal government and recoveries obtained by other states, we estimate Medicaid fraud and abuse in Colorado could exceed $20 million per year or 1.8 percent of total expenditures. In contrast, Colorado's Medicaid program recovered an average of $3.3 million per year during the past 5 years. By applying successful practices used by other states, the Colorado Medicaid program can reduce inappropriate payments and increase recoveries. Time is of the essence since, as statutes of limitation run out and records are discarded, older fraudulent or abusive payments will be unrecoverable.

Oversight of High-Risk Areas Could Be Improved

Our audit identified gaps in the Medicaid program's oversight of several high-risk areas. Specific problems we identified include:

- **Prescription credits.** The Medicaid Fraud Control Unit (MFCU) has evidence indicating that Medicaid recipients do not pick up between 2 to 3 percent of prescriptions. Our analysis found that refunds for these prescriptions are not occurring. Of 636,701 paid claims for 656 pharmacies over a three-month period, only 735 claims, or 0.1 percent, were refunds. Of these pharmacies, 27—each having more than 2,500 paid claims—had no refunds. Medicaid rules require providers to maintain records for a minimum of six years. Therefore, if only 1 percent of all pharmacy claims over the past six years should have been refunded, recoveries would be over $3 million. If 3 percent should have been refunded, recoveries over a six-year period would be over $9 million. The Department should work with the Medicaid Fraud Control Unit to recover these funds.

- **Nursing facility audits.** Current oversight of long-term care facilities is not as comprehensive as it should be. Additionally, in-depth audits of nursing facility billing practices are backlogged. Of 191 Medicaid-licensed facilities, only 18 received in-depth reviews of billing practices and resident personal fund accounts (accounts which are held and managed by nursing facilities for the benefit of the resident) during Fiscal Year 1998. Under these circumstances it is unlikely that fraud schemes, such as 1) billing Medicaid when the resident is not at the facility, 2) billing both Medicaid and Medicare for the same covered services, or 3) failing to deduct the correct patient resource amount from the bill, will be detected. Every one of the 18 in-depth audits completed during Fiscal Year 1998 resulted in recoveries. Total recoveries for the State and for nursing facility residents were $153,310 and $18,833, respectively. If backlogs were eliminated and all nursing facility billing practices and resident personal fund accounts were audited on a systematic basis, we estimate the State could recover an additional $2 million per year (this includes testing for Medicaid credit balances and discount billing). Further, we estimate nursing facility residents would recover an additional $50,000 per year.

- **Questionable utilization patterns.** The Medicaid program has not systematically conducted some basic and important claims analyses. Although the Department conducts claims analysis through its Surveillance and Utilization Review Subsystem (SURS) and ad hoc reporting, its analysis does not include evaluating certain billing relationships such as 1) payments for

- "out-of-hospital" services provided while a recipient was hospitalized, 2) services provided on holidays, or 3) services provided after a recipient has died. Analyzing basic provider billing relationships and patterns identifies questionable service utilization. (Providers include the organizations or individuals that provide the recipient with services, including physicians, hospitals, pharmacies, laboratories, nursing facilities, and home health agencies, among others.) Although basic claims analysis does not always indicate a problem exists, it is the key to identifying high-risk practices that may be highly vulnerable to fraud and abuse.

- **Unauthorized transportation services**. The county departments of social services are required to authorize certain types of transportation for recipients, such as private vehicle mileage, taxi charges of less than $50 one way, bus, mobility van, ambulance, and air or train transportation, in advance. Medicaid regulations require counties to pay for the transportation they authorize and then seek reimbursement from the Medicaid program. Medicaid regulations prohibit county transportation providers from billing the Medicaid program directly. However, we found that 3 metro area taxi companies and 33 mobility and wheelchair van companies are billing the program directly, and the Medicaid program is paying these claims. This avoids the county authorization process, making transportation services vulnerable to fraud and abuse. Additionally, it prevents the counties from ensuring, according to Medicaid regulations, that recipients use the least expensive transportation method. The Medicaid Fraud Control Unit (MFCU) is currently investigating nine transportation providers who may have billed for inappropriate transportation services. The MFCU has filed charges against another four transportation providers. The MFCU has identified over $100,000 in inappropriate transportation payments from these four providers.

- **Oversight of Medicare crossover claims.** There are about 53,000 Medicaid recipients who are eligible for both Medicare and Medicaid. Medicaid claims for these recipients are frequently "crossover claims," that is, Medicaid pays the portion of the claim that Medicare does not cover. Medicaid may contribute as much as 50 percent for certain types of claims. The Medicaid program typically pays all Medicare crossover claims without investigating appropriateness. During our review, we identified 8 psychologists with 2,325 fee-for-service claims totaling over $100,000 during a two-month period. Of these eight psychologists, six had the same billing address. We found that about 74 percent of the claims (1,731 claims) filed by these 8 psychologists were Medicare crossover claims for services to Medicaid recipients between the ages of 70 and 99 years. About 13 percent (295 claims) were crossover claims for 56 Medicaid recipients between the ages of 90 and 99.

Additionally, we identified 34 Medicare crossover claims for psychologists' services provided on Memorial Day and 19 Medicare crossover claims for a single psychologist's services on Easter Sunday. According to Medicaid Fraud Control Unit staff, the dollar value of the Medicaid program's portion of these Medicare crossover claims (in this case, 50 percent) is greater than what the Medicaid program would have paid for the service under its own rate structure. Upon further review, we also found that, for recipients who received at least 7 psychologist's services during the 2-month period, 146 were also covered for capitated mental health services through Mental Health Assessment and Service Agencies (MHASAs). The Medicaid program paid monthly capitation fees to these MHASAs on behalf of these recipients at rates ranging between $7.49 and $93.05 per month, in addition to paying for individual psychologist's services on a fee-for-service basis. The Medicaid program and the Medicaid Fraud Control Unit have reviewed some of these claims and believe that the psychologists provided these services. However, these claims have not been reviewed for medical necessity or appropriateness. Federal regulations require that all services be medically necessary. The Medicaid program needs to evaluate the medical appropriateness of these claims. Changes to program practices within the Medicaid program or at the federal Health Care Financing Administration may be warranted.

- **Oversight of services provided by other state agencies.** Medicaid program staff could be better informed about Medicaid services provided by other state agencies. Almost 100 percent of recipients are eligible for Medicaid mental health services managed through the Department of Human Services. A significant number of recipients with developmental disabilities also receive home-based support services managed by the Department of Human Services. The Department of Health Care Policy and Financing has a Memorandum of Understanding (MOU) with the Department of Human Services to address the management of these programs. The total cost of these programs is approximately $334.5 million. According to statutes, the Department of Health Care Policy and Financing is the single state agency for administering the Medicaid program, and is ultimately responsible for all Medicaid-funded services. Federal rules also require the Department of Health Care Policy and Financing to be accountable for all Medicaid services. Currently the Department provides little oversight of MOU requirements. As the single-state agency for Medicaid services, the Department must be diligent in assuring that recipients served by multiple programs are receiving necessary services at an appropriate cost.

- **Oversight of county functions.** By statute and Medicaid program policy, counties perform a number of functions on behalf of the Medicaid program, including determining eligibility and monitoring for recipient fraud. Counties are also responsible for recording date of death for Medicaid recipients. Currently the Medicaid program has serious concerns about the accuracy of date of death information recorded by counties and the Medicaid program is querying counties about recording practices. Our audit work identified a number of instances where the Medicaid program paid claims for services provided after a recipient's date of death. The Medicaid program needs to be more involved in oversight of county operations that impact program services and payments.

- **Implementation of prior recommendations.** In its internal study of Medicaid fraud and abuse, completed as required by Footnote 39 of Senate Bill 98-216, the Medicaid program made a number of recommendations for improving its oversight of fraud and abuse in Colorado. Out of 10 recommendations, we noted three important recommendations that have not been implemented. According to the Medicaid program, resource constraints have postponed implementation of one of the recommendations. Development of a new request for proposal and implementation of the new Consultec system have postponed implementation of the other two recommendations. These recommendations address controls to determine if lab tests, prescriptions, hospital billing adjustments, and emergency care practices are appropriate. Implementation of these recommendations should be a high priority. The Medicaid program should take steps to implement them as soon as possible.

The professional literature and a review of best practices from other states indicate that, to curtail fraudulent and abusive practices and increase recoveries, the Medicaid program must intensify its fraud-fighting efforts and expand its oversight of high-risk programs. This should include heightening accountability and improving the coordination of all fraud-fighting functions, including those performed by counties, other state agencies, and contractors such as the Colorado Foundation for Medical Care and private auditing firms. Specifically, the Medicaid program must implement a comprehensive fraud-fighting plan that 1) reviews all aspects of the Medicaid program for weaknesses, 2) integrates all fraud and abuse oversight functions, and 3) closes gaps that permit inappropriate payments. Additionally, the program needs to evaluate and reallocate resources available for fighting fraud and abuse, increase analytical claims review, and intensify fraud prevention efforts. With program costs of over $1 billion annually, accountability for preventing and curtailing fraud and abuse should be among the Medicaid program's highest priorities.

Recommendation No. 27:

The Department of Health Care Policy and Financing should develop an overall framework to heighten accountability for fighting Medicaid fraud and abuse. This framework should include a strategic plan that identifies weaknesses in current program operations, integrates fraud and abuse fighting activities, and closes gaps that permit inappropriate payments.

Department of Health Care Policy and Financing Response:

Agree. Although the Department submitted a fraud and abuse plan to the federal government on December 19, 1997, and updated the federal Health Care Financing Administration on that plan in June 1998, it does not contain the level of depth that is referenced in the auditor's report. We are currently developing a formal overall framework and will complete it by December 1, 1999. As part of its strategy, the Department will continue to utilize prior authorization as a fraud, abuse, and waste deterrent.

Review Programs for Weaknesses that Permit Payments for Fraudulent or Abusive Claims

On the basis of our review, the Medicaid program needs to undertake a comprehensive review of its programs with an eye toward identifying policies and practices that encourage fraud and abuse. Areas we specifically identified through our audit work are discussed below.

Recover Prescription Credit Refunds from Pharmacies

According to Department staff, the problems with pharmacy credit refunds, as discussed in the narrative to Recommendation No. 27, resulted from gaps in procedures for tracking, recording, and refunding credits for prescriptions that were not picked up by recipients. The cumbersome manual method for the pharmacies to process credits also contributed to the problem. The Department has recently taken steps to address these gaps, including:

- **Establishing time frames for returning prescriptions to inventory.** In the past, there were no time limits to determine the point when a prescription should be returned to inventory. The Department has now established a 15-day limit for this purpose. If the recipient does not pick up the prescription within 15 days, the pharmacy must return the prescription to inventory and establish a prescription credit due the Medicaid program.

- **Increasing the time frame for pharmacies to refund prescription credits to the Medicaid program.** Formerly, pharmacies were required to complete paper work and refund prescription credits to the Medicaid program within 24 hours of returning the prescription to inventory. If the pharmacy was busy, staff were not able to complete the refund within the required time and, as time passed, the paper work was never completed and the refund never occurred. Pharmacies now have a 15-day time limit to execute the refund. Refunds executed after the 15-day time limit are not in compliance with program policies.

- **Requiring pharmacies to track prescription credits through inventory logs.** Until recently, pharmacies were not required to maintain accurate inventory logs. Pharmacies are now required to maintain this information. However, pharmacies are not required to have Medicaid recipients sign for prescriptions before picking them up. Most insurance programs require their clients to sign for prescriptions. Requiring recipients to sign for prescriptions would provide an audit trail and help pharmacies maintain accurate inventory records.

- **Establishing automated procedures to prevent payment for the same prescription twice.** In the past, recipients who did not pick up their prescriptions could return to their physician, request another prescription, and get the prescription filled at a different pharmacy. If the first pharmacy did not execute a refund, the Medicaid program paid for the same prescription twice. The Medicaid program recently established automated procedures preventing payment for the same prescription more than once during a thirty-day period. If recipients do not pick up their prescriptions and decide later to do so, they must return to the first pharmacy to obtain the prescription.

Medicaid program staff believe that these steps will significantly increase the number of prescription refunds and reduce abusive pharmacy practices. However, we estimate that over the past six years, between $3 and $9 million in unrefunded pharmacy credits exist from prior weaknesses in the pharmacy program. The Medicaid Fraud Control Unit reports that, due to the lack of audit trails at small pharmacies, some of these funds will never be recovered. The Medicaid program

must take aggressive steps to recover prescription refunds from larger pharmacies where audit trails still exist. Further, Medicaid Fraud Control Unit staff report that some states have set percentage thresholds, such as one percent, for recovering prescription refunds. These states are notifying pharmacies that have made few refunds over several years and are requiring them to refund the amount of the percentage threshold. Colorado's Medicaid program could consider a similar approach. Finally, the Medicaid program must provide ongoing monitoring in the future to make sure prescription refunds are occurring as expected under the newly established practices.

Recommendation No. 28:

The Department of Health Care Policy and Financing should work with the Medicaid Fraud Control Unit to recover past-unrefunded prescription credits. Additionally, the Department should monitor future prescription refunds to make sure its new pharmacy program controls are working as intended. Finally, the Department should require pharmacies to obtain signatures from Medicaid recipients before giving the prescription to the recipient.

Department of Health Care Policy and Financing Response:

Agree. To be implemented May 1, 2000 the Department will work with the Medicaid Fraud Control Unit (MFCU) to obtain the uncollected funds from prescriptions that were billed to Medicaid but not picked up by the recipient when documentation is available. Smaller pharmacies may not and often do not keep records of returned-to-stock items. Recovery in these circumstances is not possible. If a determination is made that the Department is the appropriate agency to pursue this matter, investigative materials will be transferred from MFCU to the Department for completion of recoveries. The Department may enter into a contingency contract with an outside contractor as a method of collecting these recoveries. This will require the submission of a request for information, a request for proposals, coordination with the Medicaid Fraud Control Unit, and contract negotiations; hence the May 1 date.

By rule, the Department will require all Medicaid pharmacy providers to:

1. Require that all prescriptions billed to Medicaid, but not picked up within 14 days, will be credited back to Medicaid on the 15th day, and

2. Obtain the signature of the Medicaid recipient in the chronological log at the time of dispensing a prescription.

Medicaid Fraud Control Unit Response:

Agree. The Medicaid Fraud Control Unit will work with the Department of Health Care Policy and Financing to recover past-unrefunded prescription credits.

Expand Nursing Facility Audits

Few nursing facilities receive in-depth reviews of their billing practices or personal needs funds. Our review of best practices in other states indicates that substantial recoveries occur when all nursing facilities receive in-depth audits on a systematic basis. For example:

- **Billing practices.** The states of Virginia and Indiana perform detailed reviews of billing practices at all nursing facilities on a two-to-three year cycle and have made sizeable recoveries for their respective Medicaid programs. However, due to a backlog, Colorado is currently only performing in-depth billing reviews when a facility changes ownership. If backlogs continue, and a facility does not change ownership, there is little likelihood that they will receive an in-depth review of their billing practices. We estimate that, if the rate of recovery for all Colorado facilities were the same as those receiving in-depth audits, the Medicaid program could recover an additional $1.2 million per year.

- **Personal needs funds.** The state of Virginia also systematically reviews personal needs fund accounts at all nursing facilities on a two-to-three-year cycle. In the past year, Virginia identified fraud involving personal needs accounts at 10 facilities. The Colorado Medicaid program reviews very few personal needs fund accounts. We estimate that by reviewing all of these accounts on a systematic basis, resident accounts could be refunded a minimum of $50,000 per year.

- **Discount billings.** State regulations require the Medicaid program to pay the lowest rate at any nursing facility. In other words, the program should never pay a rate that is higher than any other payor (other payors could include the patient, his or her family members, or an insurance company). The Medicaid program requires facilities to self-report the rates they are billing their various

clients. Program staff monitor these on a monthly basis. However, the Medicaid program never verifies that it is actually paying the lowest rate, as reported by nursing facilities. One way the program could verify this would be to review for discount billings through nursing facility audits. The state of Indiana tests for discount billings at nursing facilities on a three year cycle, with high-risk providers being reviewed more frequently. It has recovered $1.8 million over three years, an average of $13 per bed per year. We estimate that, by systematically auditing discount billings at all Colorado nursing facilities, the Medicaid program could recover a minimum of $225,000 per year.

- **Credit balances.** A credit balance occurs when a nursing facility owes money back to the Medicaid program for services it billed, but did not provide, or was paid in error. For example, a nursing facility may have billed the Medicaid program for services when a recipient was discharged. The facility corrects this by showing a credit balance on the patient's account in its accounting system. Although the credit balance appears "on paper," the nursing facility may not have actually returned the funds to the State. The state of Virginia recovered almost $6.7 million over five years, an average of about $46 per bed per year, by monitoring credit balances. We estimate that, by systematically reviewing credit balances at all Colorado nursing facilities, the Medicaid program could recover a minimum of $850,000 per year.

To improve recoveries and deter abusive practices at nursing facilities, the Medicaid program should perform comprehensive reviews of all nursing facility billings on a systematic basis. This would include reviewing high-risk providers on an annual basis, while lower risk providers would be reviewed every two to three years. Contracts for in-depth audits could cost up to $10,000 per facility. Depending on how frequently the Medicaid program determines in-depth reviews are necessary, these costs could be significant. Therefore, the program will need to evaluate a number of options for ensuring systematic in-depth audits occur. For example, the Medicaid program could reevaluate the activities of its current audit functions to determine whether more comprehensive, systematic reviews could be conducted in-house, through its long-term care audit contractor, through a contingent fee arrangement, or through some combination of these approaches. Since recoveries typically drop after intensive review processes are in place and abusive practices have been curtailed, a contingent fee approach may be the most feasible alternative.

Recommendation No. 29:

The Department of Health Care Policy and Financing should address the gaps in current nursing facility audit practices by ensuring all nursing facilities receive in-depth reviews of billing practices—including review of discount billings and credit balances—and personal needs funds on a systematic basis. In evaluating its resources, the Department should determine whether to use contingent fee arrangements for this purpose.

Department of Health Care Policy and Financing Response:

Agree. The Department will review the feasibility of incorporating the recommended changes in the existing audit program for nursing facilities. This would change the scope of work of the contract auditors and require some additional resources to implement, which will require a legislative appropriation. The Department will also include nursing facilities in the contingency based contracting initiative underway in the Quality Assurance section to increase in depth analysis of billing practices. The Department has added features to the new Medicaid Management Information System MMIS to highlight those provider billing practices which indicate high risk for erroneous billings. The plan is to target these high-risk providers for in-depth reviews. Through these plans, the Department will enhance its efforts to find additional savings that are relative to the Colorado program.

Increase Analytical Review of Claims to Identify Questionable Payments

During our review, we conducted a variety of queries on a subset of Medicaid claims data and identified questionable utilization patterns that had not come to the attention of Medicaid program staff previously. One example was the volume and nature of claims paid to psychologists for services provided to a small segment of Colorado Medicaid recipients. We have suggested the Medicaid program look into the medical necessity of these claims. Without further investigation by the Medicaid program, other providers may adopt similar practices and utilization of and expenditures for these services will increase. If the Medicaid program determines these services are not appropriate, it should aggressively initiate edits, prepayment reviews, or post-payment reviews to stop or recover inappropriate payments.

One way the Medicaid program can become better aware of high-risk areas is to expand its analytical review of paid claims looking specifically for inappropriate billing relationships. Using specialized audit software, we performed analytical reviews of questionable billing relationships observed in paid claims. Although questionable billing relationships do not always result in problems or recoveries, ongoing review of these relationships is an important control for curtailing fraud.

Recently the Medicaid program acquired two new fraud-fighting systems through its new fiscal agent, Consultec. These automated subsystems, the Rapid Surveillance and Utilization Review Subsystem (Rapid SUR System) and the Services Tracking, Analysis, and Reporting System (STARS) generate reports identifying questionable service and billing patterns. The Medicaid program also has an interim reporting system called CRYSTAL. Program staff review these reports and when warranted, conduct further investigations.

These new systems promise increased capacity to do the types of analytical claims review we are suggesting. However, it is too early to determine whether these subsystems will deliver all of the fraud-fighting potential promised by the contractor. As with any new automated system, it will be important for the Medicaid program to evaluate the system's effectiveness in analyzing paid claims after it has been in place for a year or so. If there are weaknesses in some areas, the program may need to work with the contractor to upgrade the system or obtain additional software—such as computer assisted audit technique (CAAT) software—to conduct ad hoc claims analysis as required. CAAT software is relatively inexpensive and can be purchased for as little as $2,000. This software can also be used to supplement claims review in creative ways, such as comparing data maintained on the Consultec system to data maintained on other computer systems.

Finally, the professional literature indicates that computerized review of claims alone is not enough to reduce the prevalence of fraud and abuse. Expanded review of claims and problem areas, as we have suggested earlier, is also necessary. A recent study completed by the U.S. Department of Justice states:

> "However artfully constructed, automated defenses can never substitute for human common sense and will never be able to spot suspicious patterns that have not been seen before and for which they were not looking...effective fraud control systems must deal with...sophisticated, well-educated criminals, some medically qualified, some technologically sophisticated, all determined to steal as much and as fast as possible."

In the end, the Medicaid program will need to use a combination of automated and manual techniques to expand its review of programs and address the problem areas we have identified. This could include expanding claims analysis through automated

techniques and increasing post-payment review and auditing functions. A comprehensive effort will both increase recoveries and curtail fraudulent and abusive practices occurring in vulnerable programs.

Recommendation No. 30:

The Department of Health Care Policy and Financing should undertake a comprehensive review of high-risk programs that result in inappropriate payments and modify its policies and procedures to prevent payment of inappropriate claims. To achieve this, the Department should expand analytical review of paid claims to identify high-risk areas, acquiring additional computer software if necessary. The Department's review should include, at a minimum, pharmacy claims, psychologists' fee-for-service payments, nursing facility payments, home health payments, and county transportation services, as discussed above. Where the Department finds appropriate heavy utilization in one portion of the State but not in others, it must anticipate the additional expenditures that will be required as the providers take those services to additional communities.

Department of Health Care Policy and Financing Response:

Agree. The Department appreciates the validation of our continued emphasis of high-risk areas provided in the auditor's recommendation. The Department has already conducted a continuous, significant, and productive informal review that resulted in our targeting of high-risk providers such as home health, pharmacy, durable medical equipment, transportation, and Home- and Community-Based Services. The Department agrees to conduct a formal comprehensive review of high-risk programs by December 1, 1999, and make that information available to the Legislative Audit Committee by January 31, 2000.

Deterring Fraud and Abuse

Close Gaps in the Provider Application Process

The current provider application process leaves the Colorado Medicaid program particularly vulnerable to fraud and abuse. We found significant weaknesses in Colorado's process when compared to provider application practices in Florida.

Florida enacted new, stringent enrollment guidelines in December 1995. Although information is not available to precisely estimate the savings that would result by addressing these gaps in the application and enrollment process, Florida has estimated substantial savings from implementing its fraud prevention actions. The federal Health Care Financing Administration has held out the Florida program as a model for the rest of the nation to emulate. The chart that follows highlights some of the differences between Florida and Colorado's application and enrollment practices.

Comparison of the Florida and Colorado Provider Application and Enrollment Requirements

Requirement	Florida "Model Program"	Colorado
Site reviews for high-risk providers.	Yes	No
Criminal background checks.	Yes	No
Surety bonds for high-risk providers.	Yes	No
Detailed disclosure of related party arrangements.	Yes	No
Re-enrollment of existing providers.	Yes	No

The chart shows a number of gaps in Colorado's application and enrollment processes. We discuss these gaps, along with other weaknesses we identified through our review, in more detail below:

- **The program does not verify documentation submitted by providers.** Once a prospective provider completes and submits the required forms to the fiscal agent, the provider is admitted to the Medicaid program. The program does not verify the accuracy of the forms before admission and thus, cannot be sure that the provider has submitted accurate information. For example, a prospective provider must include a photocopy of its current license or certification when applying for enrollment. Since the program does not verify the validity of the license, a provider could produce a fraudulent out-of-state medical license and be enrolled into the Medicaid program. Colorado licensing agencies do not monitor or oversee these out-of-state providers. It is possible some providers may not be legitimate. Following up with the appropriate licensing agency in another state would confirm the accuracy of these providers' representations, ensure that providers have appropriate qualifications, and highlight problems that could otherwise expose the Medicaid program to fraud and abuse.

- **The program does not make sure all high-risk providers receive periodic site visits.** Certain types of providers, such as hospitals, nursing facilities, and home health agencies, receive periodic site visits by the Department of Health, the licensing agency. Other provider types, such as physicians and durable medical equipment suppliers, do not receive site visits. Without a periodic site visit, even if brief, there is no guarantee that a provider physically exists. Florida requires site visits for high-risk providers (including durable medical equipment suppliers, private transportation companies, home health agencies, non-physician-owned clinics, and independent laboratories) to reduce fraud and abuse. Colorado's Medicaid program should establish a similar approach and visit high-risk providers before admission and upon reapplication. To reduce costs, it may be possible to work with county agencies to perform these site visits.

- **The program does not conduct criminal background checks of providers before admission to the program**. Colorado's application forms also do not request key information, such as social security numbers and date of birth for owners and officers, so that a criminal background check can be completed. Adequate criminal background checks, if in place, would furnish assurance that a provider has not been convicted of a felony, made false representations or omissions of material fact, or been excluded, suspended, terminated, or involuntarily withdrawn from Colorado's Medicaid program or any other state's Medicaid program. New Jersey recently implemented criminal background checks on new Medicaid laboratory providers when it was inundated with sham laboratories. The New Jersey Medicaid Fraud Control Unit reviewed each laboratory's application before admission. Similarly, Florida requires all applicants to submit fingerprints with their applications. These fingerprints are checked against the Florida Department of Law Enforcement and FBI criminal databases. Through background checks, Florida identifies potential problem providers before they are admitted, protecting both taxpayer dollars and vulnerable clients. In Colorado, the Judicial Branch maintains an automated system for tracking court cases which the Medicaid program could use to verify backgrounds of potential providers at minimal cost.

- **Program regulations do not require surety bonds for high-risk providers**. Surety bonds serve as financial screens to discourage the enrollment of unscrupulous and undercapitalized providers. Further, bonds protect the State should a provider be unable or unwilling to refund monies owed back to the program. Finally, bonding companies perform background checks before issuing a bond, which further serves to curb fraud and abuse. Florida requires a $50,000 surety bond for durable medical equipment suppliers,

private transportation providers, home health agencies, non-physician-owned clinics, and independent laboratories. When first implemented, Florida's stricter requirements, including the surety bond requirement, resulted in 62 percent of its durable medical equipment providers resigning from the Medicaid program. Florida welcomed the reduction in durable medical equipment providers; it wanted only the most reputable companies to provide services to its Medicaid recipients. Colorado's Medicaid program should consider a similar approach.

- **Application procedures are not adequate to ensure providers disclose related party arrangements**. "Related parties" are individuals or companies that also have ownership in the provider's business. In some instances, related parties may receive kickbacks that can cause service costs to be higher than necessary. Current provider application packets do not request the provider to identify officers, directors, and principal owners in its business or in financial arrangements with other health care providers. Although the provider agreement does require providers to "disclos[e] ownership…as is required," specific disclosure requirements are not stipulated in the agreement. In contrast, Florida's application form states, "Please identify all officers, directors, and principal owners in your business (5 percent or more). List their names and social security numbers on a separate sheet on company letterhead. The list must be signed and dated by the chief officer of the business." The lack of adequate information on related parties in Colorado renders the Medicaid program highly vulnerable to additional and unnecessary charges for services. More stringent related party disclosure requirements must be instituted on provider applications immediately.

- **Contract language covering billing requirements and suspension must be more stringent.** The current contract agreement states only that a provider may be suspended or administratively sanctioned for failure to comply with federal and state rules and regulations. In contrast, Florida's agreement outlines specific billing requirements and limits provider due process rights. The agreement specifically states that all Medicaid payments in error or in excess of the amount to which the provider was entitled must be refunded within 90 days. The agreement allows either side (Medicaid or provider) to terminate the agreement with 30 days notice without cause. The agreement also states that a provider has no property right in a Medicaid provider number (i.e. the provider cannot sell its provider number when it sells its business), that the courts in one county shall have jurisdiction in all equitable matters, that the Medicaid agency shall have discretion to resolve all other matters by informal hearing, and that in the event of overlapping jurisdiction, the Medicaid agency shall determine the proper forum. As a

result of these provisions, Florida has greater latitude than Colorado to recover inappropriate payments or eliminate problem providers from the program. Additionally, Florida conducts weekly reviews of provider claims and suspends payments if it suspects a provider is submitting false claims. Colorado should revise its agreement to include more stringent language to limit the provider's due process should the program withhold payments on suspect claims. Additionally the program, with the assistance of the MFCU, should review suspect claims on a weekly basis and suspend payments until investigated. This will allow the Medicaid program to review claims before they are paid, significantly reducing the program's exposure to fraud and reducing the time and effort required to recover erroneous payments after they have been made.

- **Re-enrollment of existing providers rarely occurs.** In effect, once a Colorado provider submits an application and signs the provider agreement, that provider remains enrolled in Medicaid until the provider decides to discontinue. As a result, there is little chance that any changes in a provider's status will be disclosed to the Medicaid program. During our review, we identified provider agreements that had not been updated since originally submitted to the program. Further, the MFCU is aware of one instance where a Colorado provider used a retired physician's Medicaid provider number to bill Medicaid for services. If agreements had been terminated periodically and providers were required to re-enroll, erroneous payments could have been prevented. Florida's provider agreement automatically terminates after three to five years, depending on the provider type. Providers must re-enroll to continue providing Medicaid-funded services. When Florida implemented this practice, it also required all existing providers to re-enroll using the new enrollment forms. The re-enrollment process eliminated many providers who had not provided Medicaid services for many years. A prudent step for Colorado would be to require all existing providers to re-enroll. The re-enrollment process would utilize new, stringent provider enrollment forms including the requirements mentioned above, and would assist in updating the information originally submitted.

Florida is not the only state that has recently implemented more stringent application processes and contractual provisions. The Texas Legislature recently required its Medicaid program to develop a new provider contract with more stringent provisions directed toward reducing fraud. All Medicaid providers are required to re-enroll under the new agreement or be terminated from the program.

Although information is not available to precisely estimate the savings that would result by addressing these gaps in the application and enrollment process, Florida has estimated substantial savings from implementing its fraud prevention actions. Florida estimates it has saved $81 million and $111 million for Fiscal Years 1997 and 1998

respectively. The Florida Medicaid program is much larger than Colorado, with expenditures totaling over $7 billion per year. We cannot extrapolate Colorado savings based on Florida's experience because the programs and providers are different. However, we do believe that if the Colorado Medicaid program were to implement the changes we are suggesting, the potential savings would be substantial.

Recommendation No. 31:

The Department of Health Care Policy and Financing should, with the assistance of the Medicaid Fraud Control Unit, review and revise regulations, statutes, application materials, and provider agreements, using Florida's benchmark anti-fraud controls as a model to reduce fraud and abuse.

Department of Health Care Policy and Financing Response:

Partially agree. The Department agrees that we can improve the provider application to include more detailed disclosure of related party arrangements. The Department had also considered re-enrollment of providers as we went to the new Medicaid Management Information System with the 1995 request for proposals. However, this was delayed until after the new Medicaid Management Information System could be successfully launched. The Department will now continue with its development of a rollout plan for reenrollment of existing providers.

The Department does not plan to implement site reviews, background checks, and surety bonds because we have determined they are not cost effective.

Medicaid Fraud Control Unit Response:

Agree. The Medicaid Fraud Control Unit will work with the Department of Health Care Policy and Financing as requested.

Propose Legislation to Discourage Fraud and Abuse

Many states have specific statutes to aid their state Medicaid agencies in prosecuting unscrupulous providers. However, not all of these crucial state statutes are in place in Colorado. As a result, it is more difficult for Colorado to prosecute fraud and achieve recoveries than for many other states. Legislation is lacking in the following areas:

- **False Claims Act.** A state false claims act, modeled after the Federal Civil False Claims Act, permits recovery in civil rather than criminal court. Therefore, the level of proof is less stringent. Additionally, a false claim act typically includes harsh penalties for violators. Under the federal law, the abuser receives a fine ranging between $5,000 and $10,000 for each false claim filed, plus treble damages. However, the federal law allows treble damages only for the portion of the claim paid from federal funds. A state false claims act would allow the State to receive treble damages for state-funded dollars, increasing recoveries. Florida has a state false claims act which it uses to aggressively pursue and prevent abusive payments.

- **Anti-kickback legislation.** This statute would make it illegal for one provider to receive a monetary award from another provider when referring a Medicaid recipient for services. The legislation typically includes penalties for violators.

Additionally, Colorado lacks anti-unbundling regulations. These regulations would penalize providers that purposely unbundle items, such as lab tests, when billing Medicaid. Under correct billing practices, the provider should submit one charge for a series of lab tests conducted for a single specimen. Unbundling occurs when the provider bills for each individual test separately. This results in a higher bill, and thus, a higher payment.

Enacting anti-kickback and false claims legislation and anti-unbundling regulations will facilitate the pursuit of abusive providers and increase recoveries. Additionally it will deter fraudulent and abusive practices, reminding providers that Colorado is serious about preventing fraud and abuse and will take strong steps to prevent it.

Recommendation No. 32:

The Department of Health Care Policy and Financing should work with the Medicaid Fraud Control Unit to propose legislation that establishes anti-kickback and civil false claims statutes and anti-unbundling regulations.

Department of Health Care Policy and Financing Response:

Agree. The Department does believe that these new laws are important to successful prosecution of Medicaid fraud and abuse. In early 1999, all substantial legislation (including the 1998-drafted civil monetary penalties language) was pulled back due to the change in administration and the legislature. The Department is prepared to propose language for the state civil monetary penalties statute for false claims for the year 2000 legislative session. The Department will work closely with the MFCU who is likely to take the lead on anti-kickback legislative proposals. The Department and the MFCU are currently discussing the possibility of addressing anti-unbundling through state rule.

Medicaid Fraud Control Unit Response:

Agree. Language for an anti-kickback statute must be carefully considered to be sufficiently comprehensive to address known and anticipated conduct that should be prohibited, narrowly tailored to withstand a constitutional challenge, yet allow providers to engage in legitimate business arrangements.

Record Date of Death Timely

When a Medicaid recipient dies, county staff are required to enter the information into the Client Oriented Information Network (COIN). COIN interfaces with the claims payment system (the Medicaid Management Information System or MMIS) and is accessible at each county department of social services. Once the date of death is entered into the system, all future claims submitted for dates of service after the date of death are denied by MMIS.

Currently, there are delays in county staff learning of a recipient's death and subsequently a delay in entering the date of death into COIN. If a provider bills for services after a recipient's death, but before the date of death is entered into COIN, the provider will receive payment. If the date of death is entered later, the system does not go back and recover those payments.

As a part of our testing, we obtained the dates of death for 13 clients from two counties. Of 13 clients, 8 had HMO capitation claims paid on their behalf subsequent to their dates of death. The average value of each claim was $50. Although this is a limited sample, we were surprised by the high rate of occurrence.

The Medicaid program became aware of problems with accurate date of death information in August of 1998 and is currently conducting a study of claims paid for services after date of death. The program has also found instances of payments made after date of death and questions about date of death data in general. Issues of payments after date of death are not limited to the Medicaid program, but also occur with the Food Stamp and Social Security programs.

Our findings are consistent with a study performed by the Texas Comptroller of Public Accounts. As a part of its 1998 Fraud Measurement Study, the Comptroller's office compared the November 1997 Texas Department of Human Services' Medicaid eligibility file to the 1996 and 1997 Department of Health's vital statistics files. As a result of its review, the State found 3,395 Texans eligible for fee-for-service Medicaid programs 30 or more days after they had died, with 100 recipients still eligible a year or more after death. They also noted several of these deceased recipients were charged for services after dying, including one who was charged for services more than a year after date of death.

Upon further review of the claims included in our sample, we found the Medicaid program has since recovered all 10 of the claims paid after date of death. However, this requires resources for both paying the claim and recovering funds that should not have been paid. The program needs stronger controls to make sure it identifies date of death before payments are made. In the future, the program needs to take steps to match claims with Social Security records. Social Security records contain up-to-date, accurate date of death information because all morticians are required to inform Social Security when a person dies. The state of Florida is currently working on a project to link Medicaid information with Social Security records.

One avenue the Medicaid program should consider for obtaining accurate date of death information from Social Security databases is to link efforts with the Department of Human Services' food stamp agency. On November 12, 1998, President Clinton signed Public Law No. 105-379, dealing with providing food stamps to deceased individuals. The law directs each state food stamp agency to enter into

a cooperative arrangement with the Commissioner of Social Security to obtain information on individuals who are deceased.

In the short term, the program needs to take steps to make sure it identifies and recovers any inappropriate payments made after a recipient's date of death. There are at least two methods that the Department could consider to obtain this information.

- **Match claims against vital records.** The Medicaid program could initiate a computerized match of past paid claims against vital records maintained at the Department of Health. This would serve to identify claims that have been paid for services after date of death, and therefore, may be inappropriate.
- **Match claims against burial assistance.** The State has a program for burial assistance for the indigent. The Medicaid program could crosscheck dates of death from this program against the COIN system to identify inappropriately paid claims. This could be a simple match of electronic files.

The Medicaid program should use whichever method obtains up-to-date death information most effectively. Currently program staff indicate they plan to initiate a match with the vital records database.

If the computer match of past claims identifies inappropriate payments, the program will need to seek recoveries. If resources are not available internally, the program should consider a contingent fee contract. However, a method for identifying date of death before claims are paid is needed in the future. As we have stated, access to up-to-date death information through Social Security records, before claims are paid, provides a more effective solution.

Recommendation No. 33:

The Department of Health Care Policy and Financing should pursue the most effective and efficient method to obtain date of death information. The Department should use this information to seek recoveries for past inappropriate claims and to prevent payment for services provided after date of death in the future.

Department of Health Care Policy and Financing Response:

Agree. The Department was pursuing necessary activities to address the billing of services after the client's date of death prior to this audit. The Department encountered the inadequate data and has already negotiated fees

to coordinate data sources with the vital statistics data from the Department of Public Health and Environment. The Department identified the issue in August of 1998 and it was referred to the Program Integrity Unit for investigation. We agree to continue our progress to utilize an effective method to validate dates of death and to pursue recovery once inappropriate payments have been identified. We expect to initiate recoveries in December of this year, depending on the success of this first-time data match.

Improve Records Management

In any organization, proper management of documents is vital. When records are not managed properly, there are concerns that staff are not following required procedures. To verify that required documentation was submitted with provider applications and that the application materials were filled out completely, we sampled provider files at Blue Cross/Blue Shield, the fiscal agent during our audit. Out of 19 files reviewed, Blue Cross/Blue Shield was unable to locate one non-institutional Medicaid provider application, one provider agreement, and three Electronic Data Interchange (EDI) agreements. EDI agreements allow the provider to file claims electronically. The Medicaid program could not explain why these files were misplaced. This raises concerns about the accuracy of the application process. Five missing documents for 19 providers represents a high error rate. Missing documents can impact the success of fraud and abuse cases. Without all provider documents, a case may be difficult to prove.

Recommendation No. 34:

The Department of Health Care Policy and Financing should work with its fiscal agent to verify and document that all required application materials are included with the initial application and that application materials are filled out completely before enrollment into the Medicaid program. Current providers should be contacted for any missing application file documentation.

Department of Health Care Policy and Financing Response:

Agree. We will instruct the current fiscal agent by August 1, 1999, to continue to do a quality assurance check on all provider application documents submitted since December 1, 1998, and in the future. Updating the approximately 25,000 historical provider files transferred from the

previous fiscal agent and contacting those providers will take some time. We plan to update one fifth of those files each year until all have been reviewed and updated by July 1, 2005, starting with higher-risk providers.

Adequacy of Documentation in Children's Health Insurance Program Eligibility Case Files

The audit included testing the eligibility of children receiving benefits under the Children's Health Insurance Program (CHIP) by reviewing selected cases from the contractor administering the State's program. We noted the case files were disorganized in that the basis for determining the child's eligibility was not evident and there was no log that tracked key events, calculations, and actions taken by the contractor. In order to determine the eligibility of children in the audit sample, it was necessary to interview one of the contractor's eligibility experts in addition to reviewing the child's case file. This lack of documentation in case files results in dependence on personnel to obtain a child's status under CHIP or other information. This could become a problem if staff turnover occurs or if personnel are absent for other reasons.

Recommendation No. 35:

The Department of Health Care Policy and Financing should ensure that case files maintained by the administrative contractor for the Children's Health Insurance Program clearly document the eligibility status for each child and adequately track key activities and calculations related to the child's coverage.

Department of Health Care Policy and Financing Response:

Agree. The Department will discuss this issue at the February 2000 meeting with our administrative contractor Child Health Advocates. We will ensure that the case files maintained by the administrative contractor for the Children's Health Insurance Program clearly document the eligibility status for each child and adequately track key activities and calculations related to the provided coverage. This recommendation should be implemented by June 30, 2000.

Department of Higher Education

Introduction

The Department of Higher Education was established under Section 24-1-114, C.R.S., and includes all public education institutions in the State. It also includes the Auraria Higher Education Center, the Colorado Commission on Higher Education, the Colorado Council on the Arts, the Colorado Student Loan Division, the Colorado Historical Society, and the Division of Private Occupational Schools.

State public institutions of higher education are governed by six different boards. The governing boards and the schools they oversee are:

- **Board of Regents of the University of Colorado**
  University of Colorado at Boulder
  University of Colorado at Colorado Springs
  University of Colorado at Denver
  Health Sciences Center

- **State Board of Agriculture - Colorado State University System**
  Colorado State University
  Fort Lewis College
  University of Southern Colorado

- **Trustees of the State Colleges of Colorado**
  Adams State College
  Mesa State College
  Metropolitan State College of Denver
  Western State College

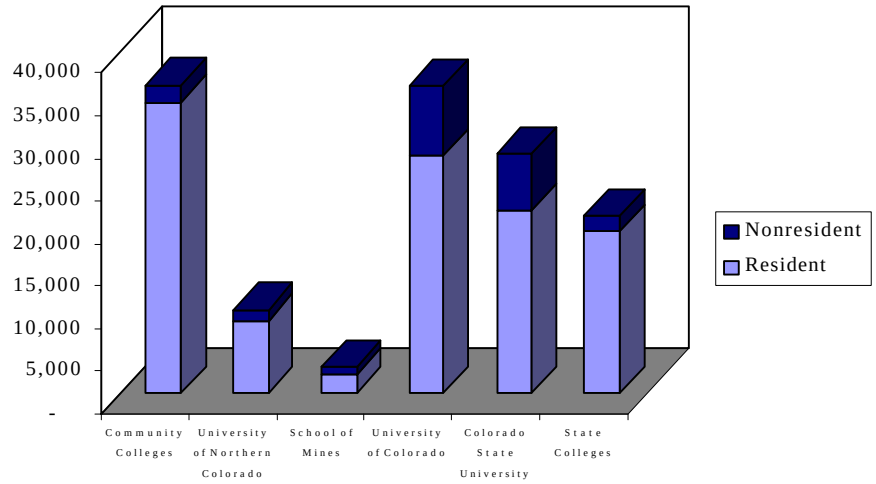
- **State Board for Community Colleges and Occupational Education (SBCCOE)**
  13 Community Colleges

- **Trustees of the University of Northern Colorado**
  University of Northern Colorado

- **Trustees of the Colorado School of Mines**
  Colorado School of Mines

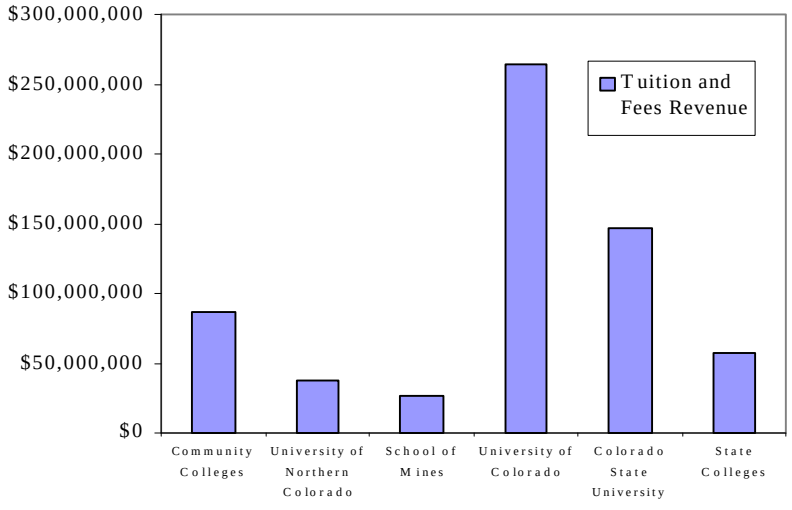
The following graphs depict comparative data between the governing boards of the State's colleges and universities:

Fiscal Year 1999
State of Colorado College & University
FTE Student Enrollment by Governing Board



Source: Financial and compliance audit reports for the applicable governing boards as of June 30, 1999.

Tuition and Fees Revenue for Colorado Colleges and Universities by Governing Board



Source: Financial and compliance audit reports for the applicable governing boards as of June 30, 1999.

Colorado Student Loan Division

The Colorado Student Loan Program (CSLP) was created by an act of the Colorado Legislature in June 1979, to assist Colorado residents in meeting expenses incurred in availing themselves of higher education opportunities. CSLP's mission is to provide students with access and choice in higher education by ensuring the availability and value of financing programs.

The following comments were prepared by the public accounting firm of Bondi & Co., who performed work at the Colorado Student Loan Division.

Resolve the Reasons why the Outstanding Check Balance Changes From One Month to the Next

CSLP maintains separate bank accounts for loan escrow activities. The bank provides a report of outstanding checks monthly, which the Division uses to prepare their bank reconciliation. The Division reviews the report of outstanding checks and identifies potential posting errors for checks and other items.

During our testing of the monthly bank reconciliations, we observed that the bank's beginning balance on the outstanding check report did not agree with the ending outstanding check balance from the previous month. In addition, several of the reconciling items were outstanding for more than six months. Although the dollar amount of the outstanding reconciling items is not significant, the changing of balances has been occurring for more than a year.

When the computer balances change between the time one report is produced and before the next month's report, it may mean that transactions are posted for which the Division is not notified. The Division identifies the differences for the bank and requests that the bank adjust their records. According to CSLP staff, these adjustments are not always made. When unknown cash transactions are posted to the account and corrections are not made timely, the outstanding checks reported by the bank to the Division may be misstated. This causes additional work for CSLP staff as well as increasing the risk of errors in the financial records.

CSLP has previously met with representatives of the bank and the State Treasurer's Office. To date, the differences have not been resolved. Errors that CSLP staff identify are not corrected by bank personnel in a timely manner. The State Treasurer's Office oversees the master banking contract for the State and also a secondary banking contract for the State. Management of the State Treasurer's Office has represented that they are willing to work with CSLP to resolve this problem.

Recommendation No. 36:

The Colorado Student Loan Division should work with the State Treasurer's Office to resolve the reasons why the outstanding check balance changes from one month to the next. The Division should ensure that differences are resolved in a timely manner.

Colorado Student Loan Division Response:

Agree. It is CSLP's opinion that the proper controls are in place to detect errors of this nature and protect the State and citizen's interests. CSLP identified this issue as a result of its monthly reconciliation process and has tried to resolve the issue by working with the bank and the State Treasurer's office. CSLP wants to resolve the issue in a timely manner, and will continue to work with the bank and State Treasurer's Office to resolve the matter during the next year.

Exercise Due Diligence to Obtain Information From the Lenders on Loans Closed by the Lender

CSLP carries loans, which have been repaid to the lender by the borrower on its financial records. The loans remain on the books until CSLP receives information from the lender. The Federal Department of Education (ED) has required lenders to report loan status information to CSLP, and in turn that information must be submitted to a federal database.

The initial submission of data from lenders to CSLP was in February 1996. At that time, according to CSLP staff, CSLP provided lenders with error reports that identified loans on CSLP's system for which the lender had provided no information. Those error reports identified an error rate of 3.9 percent. CSLP staff has been working with lenders since 1996 to update the loan information.

During the audit, we identified seven loans out of 61 tested that were paid by the borrower for which the lender had not notified CSLP that the loans were paid. Thus these loans were still shown as outstanding on CSLP's financial records. This represents an error rate of 11.4 percent. Although the error rate for the sample of loans tested during the audit may not be representative of the entire population of loans, it is a cause for concern. The seven loans identified in this audit were all on the

error report in February 1996. In November 1999, CSLP asked for updated information from the lenders regarding these seven loans.

Beginning October 1, 1998, the Division has received reimbursement from the federal government based upon the dollar amount of outstanding loans. With paid loans being included in the books, the Division may be over claiming funds from the federal government.

According to CSLP staff, all state guarantee agencies have identified lender reporting problems. As a result, the U.S. Department of Education (ED) has identified this as a national issue and has agreed to provide guarantee agencies with the ability to ensure lenders provide accurate data. Beginning in January 2000, ED plans to have guarantee agencies conduct lender reviews (audits) that include a comparison of lender data contained in the guarantee agency and federal data files. ED plans to issue a new review (audit) guide which CSLP anticipates will identify sanctions that may be imposed for improper reporting of data by lenders.

ED has also stated that it does not intend to pay guarantee agencies the maintenance fee for any loans for which the lenders have not provided status updates since July 1, 1995. During this audit, it was not feasible to estimate the current or future dollar impact on CSLP's maintenance fee revenue that may result from these changes. In addition to follow-up on the seven errors identified in this audit and planning future audits when federal sanctions are available, the Division should consider whether additional procedures could be performed now to identify potential loans in repayment status and other lender reporting issues.

Recommendation No. 37:

The Colorado Student Loan Division should continue to exercise due diligence to obtain information from the lenders on loans closed by the lender.

Colorado Student Loan Division Response:

Agree. At time of the initial lender data submission error report and on several occasions subsequent to that time, CSLP requested the lenders provide that updated loan information. As stated, the federal Department of Education has identified this as a national issue and has recognized that it did not provide guarantee agencies with the ability to ensure lenders provide the data. CSLP is working with the Department of Education to resolve the lender reporting issues, intends to implement the new review (audit)

requirements when received, and anticipates that required biannual reviews will be completed by January 2002.

Board of Regents of the University of Colorado

The Board of Regents is constitutionally charged with the general supervision of the University and the exclusive control and direction of all funds of and appropriations to the University, unless otherwise provided by law. The University consists of four campuses: Boulder, Health Sciences Center, Denver, and Colorado Springs, as well as central administrative offices. Within the four campuses, 16 schools and colleges offer more than 140 fields of study at the undergraduate level and 100 fields at the graduate level.

University of Colorado

The University of Colorado was established on November 7, 1861, by Act of the Territorial Government. Upon the admission of Colorado into the Union in 1876, the University was declared an institution of the State of Colorado, and the Board of Regents was established under the State Constitution as its governing authority.

The following comment was prepared by the public accounting firm of KPMG LLP, who performed work at the University of Colorado.

Internal Control Over Compliance Requirements Can Be Improved at the Health Sciences Center

See Recommendation No. 7 in Section II of the Schedule of Findings and Questioned Costs.

Trustees of the Colorado School of Mines

The Board of Trustees is the governing body of the Colorado School of Mines and is composed of seven members appointed by the Governor, with consent of the Senate, for four-year terms, and one nonvoting student member elected by the student body.

Colorado School of Mines

The Colorado School of Mines was founded on February 9, 1874. The primary emphasis of the Colorado School of Mines is engineering, science education, and research. The authority under which the School operates is Article 40 of Title 23, C.R.S.

Federal Grant Compliance

The School of Mines expended about $14.3 million of federal funds during Fiscal Year 1999. Approximately $1.3 million was for student financial aid and the remaining $13 million was for research and development activities. The main federal agencies that provided research and development funds to the University were the U.S. Department of Energy at $3.9 million, the National Science Foundation at $2.8 million, and the National Aeronautics and Space Administration at $2.3 million.

The federal government has established compliance and reporting requirements for the administration of federal grants. The requirements are set forth in a number of places including the Office of Management and Budget (OMB) Circular A-133, the OMB Compliance Supplement, the Code of Federal Regulations, and specific grant and contract agreements with federal agencies.

The State Controller's Office requires that each state agency report certain federal financial and program information through preparation of a Schedule of Federal Assistance. The State Controller's Office compiles the information from these schedules for all state agencies. This compilation forms the basis for preparation of the Schedule of Expenditures of Federal Awards for the State of Colorado that is submitted to the federal government.

Our audit identified areas in which the University has not maintained an internal control environment that ensures compliance with federal requirements. This could jeopardize the University's ability to receive federal funding in the future. It also can

cause inaccurate reporting of the University's federal financial assistance programs to the federal government.

Subrecipients Are Not Monitored or Properly Reported

Primary recipients of federal funds can provide grant assistance to subrecipients (i.e., entities receiving federal funds from the University). Of the three subrecipients identified on the University's Schedule of Federal Assistance, two were universities in Texas and California. Federal regulations require that primary recipients monitor subrecipients to ensure they comply with federal laws and regulations.

In Fiscal Year 1999 the University reported on its initial Schedule of Federal Assistance that it passed through $1,158,431 of federal funds through seven programs. As discussed below, our audit found that the University did not adequately monitor or report information about its subrecipients who are administering these programs.

Our review showed that two of the seven programs (29 percent) listed on the University's original Schedule of Federal Assistance were incorrectly identified as funds passed to subrecipients. These two programs were administered by University professors who were carrying out federal research activities for the University. As such, the funds should not have been reported as funds passed to subrecipients. University staff subsequently corrected this error on the Schedule of Federal Assistance after we brought this matter to their attention. This change reduced the amount of funds passed to subrecipients reported on the Schedule by $141,404, from $1,158,431 to $1,017,027.

Not only were the amounts reported incorrectly, but in addition, we could not satisfy ourselves that all entities receiving federal funds from the University have been properly included on the Schedule of Federal Assistance. This is because the University does not have an adequate process to convey the subrecipient information from the Office of Research Services to Accounting Department personnel who complete the Schedule of Federal Assistance. The University needs to design a process to identify all entities to whom it disburses federal funds and evaluate whether they are subrecipients that should be reported on the Schedule of Federal Assistance.

Further, the University needs to establish mechanisms to monitor subrecipients so the University is in compliance with the federal requirements. As a pass-through entity, the University is responsible for:

- Monitoring the subrecipient's activities to provide reasonable assurance that the subrecipient administers federal awards in compliance with federal requirements. This can be accomplished by implementing a system to a) regularly contact the subrecipients and make the appropriate inquiries concerning the federal program; b) monitor subrecipient budgets; and c) review financial and programmatic records.

- Ensuring required audits are performed and requiring the subrecipient to take prompt corrective action on any audit findings. This could include determining whether the subrecipients met the thresholds requiring an audit under OMB Circular A-133. If an audit is required, the University should ensure that the subrecipient submits the reports and documents required by OMB circulars to the federal government and the University.

- Communicating to the subrecipient the federal award information and applicable compliance requirements. There should be written policies and procedures to establish communication of federal award requirements to subrecipients. Further, all agreements with subrecipients should include the requirement to adhere to the compliance requirements applicable to the federal program, including the audit requirements of OMB Circular A-133.

- Determining and evaluating the impact of any subrecipient noncompliance on the University's federal programs.

The University's Office of Research Services has not established a subrecipient monitoring process to meet the above responsibilities. As a result, we were unable to determine whether the University complied with applicable federal laws and regulations regarding subrecipient monitoring, and whether subrecipients were in compliance.

This finding affects the following CFDA numbers: 12.F49620-98-1-0060, 43.NCCW-0096, 66.502, 81.KH800022MW, 93.5R01-ES06825-02.

Grant Close-Out Reports Continue to Be Submitted Late

Federal rules and regulations generally require that close-out reports be submitted to federal granting agencies within 90 days of project completion. These reports can include both fiscal and programmatic information. Both the 1997 and 1998 financial and compliance audits of the University reported that the University was not submitting federal grant close-out reports and reimbursement requests in a timely manner.

In reviewing lists of contracts pending closure and contracts closed out in Fiscal Year 1999, we noted the timely closure of federal projects continues to be a problem. Of the 42 contracts pending closure at the end of Fiscal Year 1999, 33 (79 percent) were late for close-out. Almost half (48 percent) of these relate to grant projects with end dates from one to seven years old. Of the grants that were closed in Fiscal Year 1999, 26 percent were projects closed over one year after the project end date.

The University has instituted new procedures and devoted additional resources to close-out contracts over the past two years. However, a large backlog of close-out reports continues to exist. The University does not have a formal plan on how or when it will eliminate the backlog. Developing such a plan would enable the University to measure its progress in eliminating the backlog.

This finding affects the following CFDA numbers: 15.1434-CR-96-SA-00220, 47.OCE-9416088, 81.XAF-5-14142-11, 66.502, 10.652, 47.EEC-9622627, 47.ESI-9553529, 81.KCR-6-15329-04, 47.DMI-9709408, 12.DAAG55-98-1-0070, 47.EIA-9732601, 83.EMW-95-C-4770, 15.CKB00133495; MOD 5, 81.DE-AC07-95ID13274, 81.KCR-6-15329-07, 81.XCO-8-18100-01, 81.AAD-8-18669-04, 81.KCR-6-15329-08, and 15.PO 16062. This finding also involves federal funds received from Applied Technology Council and the University of Utah as pass-through entities from the Federal Emergency Management Agency and the Department of Energy, respectively.

Documentation Showing Compliance With Matching Requirements Should Be Retained

Matching requirements provide for the University to pay a specified amount or percentage of federal costs in cash or in-kind contributions. The specific matching requirements are unique to each federal program and are found in the laws, regulations, and contract or grant agreements for each program.

In our review of federal matching requirements, we found that the University does not maintain information to determine whether it met all federal matching requirements. The University needs to retain appropriate documentation to show that the matching calculations and accounting entries made meet federal matching requirements. This should include retaining spreadsheets. It also would be useful to maintain a file showing all the grants requiring a match as well as a copy of the contract or grant provision that specifies the matching requirement.

This finding affects the following CFDA numbers: 47.CDA-9214573, 47.EAR-9316197, 66.502, 47.CTS-512228, 47.CMS-9512434, 47.ECS-9523327, 47.ESI-9553529, 47.CTS-9634899, 47.DUE-9750764, 47.EAR-9707054, 47.CTS-9711889,

47.CTS-9700312, 12.DAAH04-94-G-0344, 47.CTS-9734136, 47.DUE-9851197, 47.DMS-9872005, 47.DUE-9850556, 66.R 826684-01-0, 12.630, 47.DAM-9876135, 66.500, and 47.ANI-9996156. This finding involves federal funds received from the University of Kentucky as a pass-through entity from the Department of Defense.

Non-Cash Assistance Is Not Reported on the Schedule of Federal Assistance

For federal reporting purposes, the State Controller's Office requires that state agencies disclose the value of non-cash federal assistance on their Schedule of Federal Assistance. The University's Office of Research Services told us that the University sometimes receives non-cash federal assistance for a project in the form of equipment or computers.

There is currently no process in place to report non-cash assistance on the Schedule of Federal Assistance. The University needs to establish a mechanism for doing so to enable it to meet federal reporting requirements.

This finding affects CFDA number 81.XAK-8-17619-28.

Recommendation No. 38:

The Colorado School of Mines should establish policies and procedures to ensure compliance with federal requirements by:

a. Identifying all entities that receive federal funds from the University and evaluating which entities are subrecipients; monitoring subrecipients as dictated by the federal government.

b. Developing a plan and timetable for eliminating the backlog of grant close-out reports and measuring its progress against the plan.

c. Retaining appropriate documentation to demonstrate compliance with federal matching requirements.

d. Reporting non-cash assistance in accordance with federal requirements.

Colorado School of Mines Response:

a. Agree. Fiscal Services and the Office of Research Services will coordinate efforts to accurately identify subrecipients of federal funds and adequately monitor those subrecipients as required by the federal government. Our monitoring efforts will include regular contact with subrecipients, the comparison of actual expenditures with approved budgets, and the required review of any audit findings and related corrective actions. Implementation–March 2000.

b. Agree. The University will establish a plan and continue to pursue elimination of the backlog of pending federal project closeouts. It should be noted that 14 of the federally funded projects pending closure at June 30, 1999 were funded by one agency. That agency withholds 1 percent retainage, which is not released until a desk audit of the project is conducted, sometimes years after the project end date. Accordingly, the University can not realistically expect to eliminate the backlog of pending closures unless we are successful in negotiating a policy change with that agency. Implementation–June 2000.

c. Agree. The University reviews all closing projects to assure compliance with matching requirements. Fiscal Services will improve the retention of documentation (including copies of interim spreadsheets supporting the matching calculations) that demonstrates our compliance with federal matching requirements. Implementation–January 2000.

d. Agree. Fiscal Services will establish a mechanism to include non-cash assistance in our Schedule of Federal Assistance. Implementation–June 2000.

Department of Human Services

Introduction

The Department of Human Services is solely responsible, by statute, for administering, managing, and overseeing the delivery of human services throughout the State. Services include the following: Welfare, vocational rehabilitation, mental health, youth corrections, and developmental disabilities. The Department accomplishes its statutory responsibility through a variety of state-operated facilities and programs, county-operated programs, and contractual arrangements with public and private human services providers across the State. In Fiscal Year 1999 the Department expended approximately $1.4 billion and had 4,464.4 full-time-equivalent staff (FTE).

We reviewed and tested the Department's internal accounting and administrative controls and evaluated compliance with state and federal rules and regulations. Generally, we found the Department to have adequate administrative and internal controls in place to oversee its operations and meet state and federal requirements. We identified four areas where improvements could assist the Department in effectively managing its responsibilities.

Improve Monitoring Process In Place Over Adoption Assistance Program

In Fiscal Year 1999 the Department expended approximately $18.4 million for the operation of the Adoption Assistance (CFDA 93.569) program. This program, which is governed by Title IV-E of the federal Social Security Act, was established to provide financial assistance on behalf of children with special needs to help defray costs related to the adoption of these children. Children with special needs may include the following:

- A child who is physically or mentally disabled.
- A child aged 7 or older.
- Infants diagnosed with Human Immunodeficiency Virus (HIV).
- A child who is a member of a minority group.

The Adoption Assistance program is overseen by the Department's Division of Child Welfare Services within its Office of Children, Youth, and Families and administered locally by the county departments of social services. Under the program, an adoptive family may receive monthly subsidy payments to assist them with costs incurred related to the child's special need. These subsidies can be awarded on either a "time-limited" or long-term basis. Counties are required to annually redetermine the appropriateness of subsidy payments awarded. In Fiscal Year 1999 these payments accounted for nearly $13 million, or 71 percent, of the Department's total Adoption Assistance expenditures.

The federal Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) requires states to have a periodic review process in place to ensure that adoption assistance payments are made appropriately. We found that the Department's monitoring process for Adoption Assistance maintenance payments is lacking. Specifically, we noted the following:

- No systematic plan is in place for selecting counties to be reviewed.
- Cases for review are not selected in a systematic manner.
- Review procedures are not documented.
- Results of the reviews are not documented and provided to county supervisors or management.
- Counties are not required to correct noted deficiencies through the Department's formal corrective action process.

State Adoption Assistance staff reported that they reviewed records related to county staff's annual redetermination of subsidy payments at six counties during Fiscal Year 1999. However, without a better defined and documented process, it is unclear whether the Adoption Assistance program is adequately monitored and problems identified are corrected.

We noted that the Department's Foster Care Review Team has a system in place for reviewing maintenance payments for children placed in Foster Care families. These processes are documented and results are provided to county management. In addition, counties must correct the problems identified within 30 days or be subject to the State's corrective action process.

The Department's Adoption Assistance Program should implement a similar formalized system to monitor county compliance with federal regulations and to ensure state and federal dollars are spent appropriately.

Recommendation No. 39:

The Department of Human Services should improve its on-site review process for the Adoption Assistance Program by:

a. Implementing a risk-based approach for selection of counties to be monitored.

b. Using a random-sampling method for case file selection.

c. Documenting review procedures to be performed.

d. Providing written results of the review to appropriate county management.

e. Requiring counties to correct noted deficiencies through the Department's formal corrective action process.

Department of Human Services Response:

a. Agree. The Department will review the number and kinds of technical assistance requests from a specific county and complaints from consumers to identify counties to be monitored.

b. Agree. The Department will conduct a Stage I review of five percent of the adoption assistance cases in any ten large county identified for review and three percent of the cases in any balance of the state county identified. If a county fails the minimum threshold, then the Department will conduct a Stage II review of ten percent of the adoption assistance cases. The Department will randomly select cases from the monthly adoption assistance report. Counties outside of the metropolitan area will be requested to mail cases to the state office for review.

c. Agree. The Department will develop a modified review instrument based on the Federal Adoption Assistance instrument for case review.

d. Agree. The Department will send a written report to the county director within 14 working days identifying the outcomes of the review. Compliance issues must be corrected and documentation of corrected items provided to the Department of Human Services within 30 days of receipt of the written report.

e. Agree. The Department of Human Services will develop a Corrective Action Plan when a county department fails to comply with correcting the errors within 30 days of receipt of a written notice.